ASSEMBLY BILL 8 (NUÑEZ) AS AMENDED JULY 18, 2007

AB 8 encompasses a comprehensive approach to reforming California's broken health care system based on the principle of shared responsibility between government, individuals and employers. AB 8 contains major reforms of the insurance industry, expansion of public health care programs, cost containment, measures to improve health care quality, and provisions to strengthen the private health care market.

INSURANCE MARKET REFORMS

INDIVIDUAL MARKET REFORMS (effective 1/1/09 and 1/10/10)

- The individual market today is the main source of coverage for people ineligible for employer-based or public coverage. It can be an extremely difficult to buy coverage in the individual market as carriers can and do decline to cover people because of their occupation or pre-existing medical condition, or they are charged higher premiums because of their medical history. The process of medical underwriting often is confusing, extensive, and varies widely carrier to carrier. AB 8 requires a standardized health questionnaire to be used by all health plans and insurers in screening applicants for individual health insurance coverage. The questionnaire would provide an objective evaluation of a person's health status, and is designed to identify the 3-5% of people who are most expensive to treat under an individual policy. These individuals would then be eligible for the Major Risk Medical Insurance Program (MRMIP), the state's high risk program for medically uninsurable individuals. This requirement would take effect January 1, 2009.
- AB 8 requires the Managed Risk Medical Insurance Board (MRMIB) to develop a list
 of serious health conditions or diagnoses that make an applicant automatically
 eligible for MRMIP. Health plans and insurers would be prohibited from excluding
 people from individual coverage if they do not have a condition on the list developed
 by MRMIB.
- By January 1, 2010, health insurance regulators would be required to adopt regulations governing five classes of individual health benefit plans that health plans and insurers must make available (except for those individuals identified by the

standardized health questionnaire as the 3-5% of persons who are the most expensive to treat). Health plans and insurers would be required to guarantee issue (not turn down from coverage) all other applicants. This would require health plans and insurers to compete on the basis of the price of their premiums, the quality of their provider networks, and their customer service, and not on avoiding individuals insurers consider to be high risk.

MID-SIZE MARKET REFORMS (effective 7/1/08)

- The mid-size market consists of 6% of California businesses and 17% of California employees. Unlike small employers with 2-50 employees who receive the regulatory protection offered under health insurance reforms enacted in the 1990s, health plans can and do refuse to sell to mid-size firms. Some employers in the mid-size market with poor claims experience are either unable to obtain a quote from a health plan or have difficulty getting an affordable quote, and these difficulties are concentrated in industries with higher rates of low-income employees.
- AB 8 builds upon the successful small employer health insurance reforms by extending them to employers with 51 250 employees. As is the case for employers with 2 50 employees, health plans and insurers selling to mid-size employers would be required to guarantee issue all health insurance products, publish rates, and enact rate bands to limit the variation in premiums charged, which stabilizes the rates upon renewal. Additionally, AB 8 would phase out the rate bands in both the small group and mid-sized market that enables health insurers to vary rates by plus or minus 10% from standard rates filed with their regulators. The phasing out of the rate bands would occur before enrollment in the purchasing pool created by the bill (called the California Cooperative Health Insurance Purchasing Pool Program or Cal-CHIPP) begins.
- Extending the small group reforms to employers of 51 to 250 employees creates price transparency in rates and a fairer, more level, market place. It prevents a mid-sized employer that wants health insurance coverage from being declined coverage, and it will provide greater freedom for mid-size groups to shop and shift coverage at renewal by eliminating the option health plans currently have to decline-to-quote. The requirement for published rates would make purchasing easier, competition more transparent, and would prevent secret rates to certain purchasers by requiring that all

health insurance products be sold to all prospective purchasers. This would prohibit redlining of industries, such as those with a high percentage of low-income employees.

MINIMUM MEDICAL LOSS RATIO FOR HEALTH PLANS AND INSURERS (effective 7/1/09)

- AB 8 requires the state's two health insurance regulators, the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI), to each adopt a regulation that would require at least 85% of revenue the plan or insurer receives be spent on health care services, a requirement commonly referred to as a "medical loss ratio."
- Additionally, plans and insurers would be required to disclose to all prospective purchasers the medical loss ratio, instead of only to individuals and groups of 25 or fewer employees as required under existing law.
- Under current law, health plans regulated by the DMHC are prohibited from
 expending an "excessive amount" on administrative costs in any fiscal year. The
 Insurance Commissioner is required to withdraw approval of individual policies if the
 commissioner finds that the benefits provided under the policy are unreasonable in
 relation to the premium charged. However, this requirement to withdraw individual
 policies does not apply to group policies regulated by DOI.
- Establishing a minimum loss ratio will enable purchasers to know how much of each
 dollar they spend on health insurance premiums goes to health care expenditures.

 Expanding the existing disclosure requirement to all groups purchasing coverage
 (instead of just individuals and groups of 25 or fewer employees) will help all
 purchasers determine if they are getting value for the dollars they spend.
- The medical loss ratio has been successfully implemented in the Healthy Families Program. MRMIB currently requires its Healthy Families Program-contracting health plans to meet a contractual requirement that each plan spend 85% of premiums received on total covered benefit and services costs. MRMIB uses this data, among other data, when conducting rate negotiations with health plans to determine if rate increase requests are warranted based on the previous year's claims history.

PUBLIC COVERAGE EXPANSIONS FOR LOW INCOME CHILDREN AND ADULTS

AB 8 makes several changes to expand and simplify health insurance coverage for California's uninsured children and adults, effective 7/1/08.

PROVISIONS RELATING TO CHILDREN (effective 7/1/08)

- Expands income eligibility for the Healthy Families Program (HFP) from 250% of the federal poverty level (at or below \$42,925 for a family of three in 2007) to 300% of the federal poverty level (at or below \$51,500 for a family of three in 2007).
- Families of children in this expansion population would pay monthly premiums of \$22 to \$25 per child, with a maximum monthly premium of \$75 per family.
- Keeps families together by establishing a Medi-Cal floor at 133% of the federal poverty level (at or below \$22,836 for a family of three in 2007) for all children ages 1 to 18. Low income families with children of different ages find themselves in split families, with some children in Medi-Cal and others in Healthy Families, which have different networks and cost sharing requirements. For example, under current law, infants 0 -1 in families with incomes up to 200% of the FPL are eligible for Medi-Cal. However, those income limits drop for children age 1 to 5, so that family income can only be up to 133% of FPL in order to stay on Medi-Cal. Those income limits change again for children ages 6 to 18. These children are eligible for Medi-Cal only if their family income is below 100% of FPL.
- Under AB 8, all children ages 1 to 18 with incomes below 133% FPL would be eligible for Medi-Cal. All children 1- 18 with incomes between 133% and 300% FPL would be eligible for the Healthy Families Program.
- AB 8 maintains existing law for infants 0 to 1 (can have family income up to 200% of FPL to be eligible for Medi-Cal).
- Makes the full scope Medi-Cal and Healthy Families Programs available to undocumented children that would qualify for these programs but for their

documentation status.

PROVISIONS RELATING TO PARENTS (effective 7/1/08)

- Expands eligibility in Medi-Cal and Healthy Families to low-income, working parents of children with family incomes between 100% (at or below \$17,170 for a family of three in 2007) and 300% of FPL.
- Currently, parents with family incomes below 100% of the federal poverty level are eligible for Medi-Cal under a provision in federal law known as "1931(b)" that was enacted as part of the 1996 federal welfare reform legislation to ensure that people moving from welfare to work did not lose their health coverage through Medicaid. Eligibility for 1931(b) at application is 100% FPL, but once a recipient is enrolled in 1931(b), his or her income can grow to approximately 150% FPL and still remain eligible.
- AB 8 expands Medi-Cal 1931(b) coverage to 133% FPL, enabling the parents of children ages 1 to 18 to receive coverage through the same program as their children.
- Parents with family incomes between 133% and 300% FPL at application would enroll in a Healthy Families benchmark benefit package via a statewide purchasing pool (Cal-CHIPP) established under the bill, using the authority granted to states under the federal Deficit Reduction Act of 2005. This federal law would enable the state to draw down federal Medicaid funds while using a different benefit package (the Healthy Families benefit package) to expand coverage.

PREMIUM ASSISTANCE and BENCHMARK PLANS (effective 7/1/08)

AB 8 requires group health plans and insurers to offer a Medi-Cal benchmark plan
and a Healthy Families benchmark plan so that group members and their dependents
with incomes below 300% FPL who are eligible for coverage through the Medi-Cal
or Healthy Families Programs can enroll in the applicable benchmark plan. MRMIB

would negotiate the rates for this coverage with health plans and insurers, and the plans and insurers would be required to collect the employer's applicable dollar premium contribution and credit that amount towards the cost of the applicable benchmark plan.

• If a health plan or insurer did not directly provide benchmark coverage, the health plan or insurer would instead be required to collect the employer's dollar premium contribution for Medi-Cal or HFP-eligible enrollees and dependents and credit that amount to MRMIB towards the premium cost of a Medi-Cal or Healthy Families benchmark plan in Cal-CHIPP.

ENROLLMENT SIMPLIFICATION (effective 7/1/08)

- AB 8 simplifies the Medi-Cal application process and reduces program administrative costs by eliminating the use of the countable property limit known as the "assets test" in 1931(b). Under current law, in order to be eligible for 1931(b) Medi-Cal coverage, a family's countable property cannot exceed certain dollar thresholds depending upon the number of people in the family (for example, \$3,000 for 1 to 2 people, \$3,150 for three people). Because AB 8 is expanding the 1931(b) program to low-income working adults that will have assets, such as savings accounts, the asset test needs to be eliminated in order to expand coverage.
- To promote continuous coverage and continuity of care, AB 8 would eliminate the
 requirement that certain adult Medi-Cal beneficiaries file a semiannual status report.
 Medi-Cal beneficiaries would still be required to submit an annual reaffirmation form
 to indicate their ongoing eligibility for the program.

BUILDING UPON THE EXISTING HEALTH CARE SYSTEM (effective 1/1/10)

In addition to building upon the existing public health care system, AB 8 strengthens the financing of the private health care system by creating additional options and responsibilities for individuals and employers.

• Establishes an employer election to either make health care expenditures equivalent to 7.5% of Social Security wages (capped at \$97.500 in 2007) or pay an equivalent amount to the California Health Trust Fund, which this bill establishes. Employers

could elect to directly make health care expenditures for all of their full-time employees or part-time employees or could elect to make health care expenditures for one or both groups of employees.

- Establishes the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) as a state purchasing pool to be administered by MRMIB, to negotiate and contract with carriers to provide health insurance for employees and their dependents who work for employers who elect to pay a fee. Individuals eligible for Medi-Cal or Healthy Families who are employees of a pay employer would receive their Medi-Cal or Healthy Families coverage through a benchmark plan in Cal-CHIPP.
- Requires individuals eligible for Cal-CHIPP to enroll in Cal-CHIPP, unless that
 individual demonstrates other group coverage (such as retiree health coverage or
 coverage through a spouse), coverage through a public program, or individual
 coverage in effect on January 1, 2010.
- Qualifying health care expenditures include contributing to a health savings account, reimbursing employees for health care expenses, establishing programs to assist employees attain and maintain health and healthy lifestyles (such as on-site health fairs and clinics), disease management programs, or buying health care coverage from a health plan or insurer.

COST CONTAINMENT PROVISIONS

Health care costs continue to rise dramatically, placing health care out of reach for both employers and individuals. In 2004, health spending in California increased 8% compared to a 3.7% increase in the overall Consumer Price Index (CPI). AB 8 would take several concrete steps to stem this rising tide of escalating costs.

EMPHASIS ON PREVENTION AND WELLNESS

<u>Preventive services</u>. All of the state-developed uniform benefit designs will include coverage for primary and preventive care with minimal patient cost sharing, including the essential maintenance medications that allow patients to cost-effectively manage their chronic conditions, such as asthma, diabetes and heart disease. In 2006, RAND estimated that on a national basis reducing drug co-payments for sicker patients on

cholesterol-lowering drugs could save a billion dollars per year in other medical costs.

<u>Disease Management</u>. The state will implement, in every state health coverage program, including the California Public Employees Retirement System (Cal-PERS), Medi-Cal, Healthy Families, and Cal-CHIPP, best practices in the care and treatment of persons with high cost chronic diseases, such as asthma and diabetes. The proposal calls for the California Health and Human Services Agency to spearhead professional review and development of best practice standards.

<u>Pay for Performance</u>. The state will take the lead in rewarding quality health care services and providers by initiating a common Pay for Performance model in every health coverage program receiving state dollars. By ensuring that precious state dollars are focused on quality providers, the state can reward best practices, spur a reduction in medical errors and waste, and improve the health outcomes of its workforce.

TAX SAVINGS FOR EMPLOYERS AND EMPLOYEES

- Under Section 125 of the Internal Revenue Code, employers can allow employees to
 pay their portion of health insurance premiums on a pre-tax basis. AB 8 would
 require employers to establish a 125 Plan that will allow employees to pay their
 portion of health care premiums with pre-tax, rather than post-tax dollars, using
 existing federal and state tax preferences to stretch dollars further.
- Employers and employees benefit from the establishment of a Cafeteria Plan with an
 overall reduction in federal and state tax. Employees do not pay Federal Insurance
 Contributions Act tax (FICA), federal, or state tax on money used to pay for their
 portion of employer-sponsored health insurance premiums.
- Employees' tax savings help lower their out-of-pocket cost of health insurance premiums.
- Employees can increase their take-home pay.
- The Cafeteria Plan reduces the employer's taxable payroll by the total amount of employee contributions for benefits.

UNIFORM BENEFIT DESIGN

- AB 8 requires the Managed Risk Medical Insurance Board to develop and offer at least three uniform benefit plans designs within Cal-CHIPP, with varying benefit levels, deductibles, coinsurance and annual limits on out-of-pocket expenses.
- Health plans and insurers would be required to sell these uniform benefit plan designs in all individual and group markets where the plan provides services.
- Uniform benefit designs will permit more meaningful comparisons by employers and
 individuals, allowing "apples to apples" comparison of different coverage options
 based on price, network and quality, and by focusing rate negotiations with health
 plans on the cost of the plan, rather than co-payments and benefit design.
- Uniform benefits will simplify plan selection for purchasers and ease the administrative burden for providers.
- In 1993, CalPERS implemented a standardized health benefits package structure that
 all participating HMOs had to offer. A GAO report on the CalPERS health program
 reported that benefit standardization was one factor contributing to slower premium
 growth by focusing rate negotiations on the cost of plans, instead of benefit plan
 design and co-payment differences.

REDUCING UNCOMPENSATED CARE REDUCES THE COST SHIFT

• All health care purchasers experience higher costs to make up for the costs of serving uninsured persons. While the amount of this cost shift to insured patients is not known, a New America Foundation study estimated the average private sector cost-shift related to care for the uninsured is likely to be as much as 10%, or \$1,186 annually for a California family and \$455 per year for an individual. As the number of uninsured persons drops, uncompensated care costs will be reduced. Reducing the number of uninsured persons ensures their access to primary care so they do not unnecessarily use more expensive emergency rooms when they need health care.

EVALUATION

AB 8 would require the California Health and Human Services Agency to contract with a nonprofit group, foundation, academic institution or governmental entity to track and assess the effects of health care reform. An advisory body with legislative and gubernatorial appointments would guide the assessment, and the advisory body and Agency would establish a timeline for reporting to the Legislature. The assessment would be far-reaching and would include the number of people receiving coverage through the purchasing pool, the cost and affordability of health care, the quality of health care services, and the change in access and availability of health care throughout the state.